

**Regular Mailing Address**  
 STATE BOARD OF MEDICINE  
 P.O. BOX 2649  
 HARRISBURG, PA 17105-2649

Email: [st-medicine@pa.gov](mailto:st-medicine@pa.gov)

## APPLICATION FOR A PERFUSIONIST TEMPORARY EMERGENCY LICENSE FOR PERFUSIONISTS LICENSED IN ANOTHER STATE

- This application is to be used only by Perfusionists seeking temporary emergency licensure in the Commonwealth of Pennsylvania to aid in the Commonwealth's emergency declaration related to COVID-19.
  - To Qualify for a Temporary Emergency License, You Must Hold an Active Perfusionist License in Good Standing in Another State.
  - If you previously held a Pennsylvania perfusionist license and are seeking to reactivate the license due to the emergency **DO NOT SUBMIT** this application. Submit the reactivation posted on our website at [www.dos.pa.gov/med](http://www.dos.pa.gov/med) (Medicine) and [www.dos.pa.gov/ost](http://www.dos.pa.gov/ost) (Osteopathic Medicine).

### REQUIRED DOCUMENTS

1.	Complete Pages 1 and 2 of the application.
2.	Include a copy of your active license verification from the website of your home licensure state.
3.	Scan and email the application to <a href="mailto:St-Medicine@pa.gov">St-Medicine@pa.gov</a> . The subject line of the email should be listed as Perfusionist Emergency Temporary License.
4.	Upon completion of your application, a temporary license will be issued with an expiration date of <b>December 31, 2020</b> . This temporary license is non-renewable. If you wish to practice after the declared state of emergency, you will need to obtain full licensure by meeting all standard licensing requirements. You can determine if you meet the Board's requirements by reviewing the Board's Rules and Regulations posted on our website at <a href="http://www.dos.pa.gov/med">www.dos.pa.gov/med</a> . You can also review the applications instructions at <a href="http://www.pals.pa.gov">www.pals.pa.gov</a> . Click on Application Checklist.

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**APPLICATION FOR A PERFUSIONIST TEMPORARY EMERGENCY LICENSE**

**APPLICANT INFORMATION**  
(Please Print or Type)

<b>NAME:</b>	Last	First	Middle
<b>ADDRESS:</b>	Street		
City	State		ZIP
<b>DATE OF BIRTH:</b>	Month	Day	Year
<b>SOCIAL SECURITY NUMBER:</b>			
<b>EMAIL ADDRESS:</b>			
<b>NAME OF SCHOOL ATTENDED:</b>			
<b>DATE OF GRADUATION:</b>	Month	Day	Year
<b>CURRENT STATE LICENSE BEING USED TO APPLY FOR A TEMPORARY LICENSE IN PA:</b>			

**NAME AND ADDRESS OF PENNSYLVANIA PRACTICE LOCATION**

<b>NAME OF ORGANIZATION:</b>			
<b>ADDRESS:</b>	Street		
City:	State		ZIP

**LEGAL QUESTIONS**

**You must answer the following questions.** If you answer "YES" to #2 through #11, provide complete details on a separate sheet as well as copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice in any health-related profession in any state or jurisdiction? <b>If you answered yes, provide the profession and state or jurisdiction.</b> <b>LIST:</b> _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
6	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
7	Have you had your DEA registration denied, revoked or restricted?		
8	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
9	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
10	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
11	Since May 19, 2002, have you been the subject of a civil malpractice lawsuit? <b>If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.</b> <b>**If you previously reported the complaint to the Board provide the docket number _____</b>		

**SIGNED STATEMENT**

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. § 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant